

Pure Resolutions LLC

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 10/05/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Outpatient Right Shoulder Labral Repair and Biceps Tenodesis

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male who reported an injury to his right shoulder. The MRI of the right shoulder dated xxxxxx revealed intact rotator cuff tendons. No evidence of a tear was identified. Mild tendinosis was identified involving the supraspinatus tendon. Mild hypertrophic changes were identified at the acromioclavicular joint. The clinical note dated 07/02/15 indicates the patient having undergone injection at the right shoulder. The patient reported near complete relief for several days. However, the patient reported a return to baseline levels of pain. Upon exam, tenderness was identified at the anterior surface of the right shoulder. The patient was able to demonstrate 100 degrees of both abduction and flexion. Normal external rotation was identified. The patient reported on two occasions he was unable to actively move the shoulder. The clinical note dated 07/23/15 indicates the patient continuing with right shoulder pain. Patient said the initial injury occurred when he was xxxx on xxxxxx. The note indicates the patient having undergone physical therapy but was not undergoing any home exercises. The note indicates the patient able demonstrate 30 degrees of external rotation and 180 degrees of scaption appeared right the therapy note dated 08/03/15 indicates the patient a can having completed four physical therapy sessions to date. The utilization reviews dated 07/29/15 and 08/14/15 resulted in denial as no information was submitted regarding a significant SLAP tear or biceps tenet tendinitis on.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The documentation indicates the patient complaining of ongoing right shoulder pain with associated range of motion deficits. A labral repair and biceps tenodesis indicate for patients with imaging studies confirming the patient's significant pathology and the patient has completed all conservative treatments. There is indication the patient has undergone four physical therapy sessions to date. However, no information was submitted regarding the patient having complete a full course of conservative therapy. Additionally, no information was submitted regarding the patient undergoing an ongoing home exercise program. Furthermore, the submitted imaging studies reveal no evidence of a SLAP lesion. No information was submitted of patient's significant labral involvement. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for an outpatient right sole shoulder labra repair and biceps tenodesis is not

indicated as medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☒ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☒ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)